Number	Category Name	Category Description	HL7 BH Conformance Profile Classification CM = Care Management
	Functional Requirements		
F01	***Identify and maintain a client record***	Key identifying information is stored and linked to the client record. Both static and dynamic data elements will be maintained. A look up function uses this information to uniquely identify the client.	DC \ Care Management
F02	***Manage client demographics***	Contact information including addresses and phone numbers, as well as key demographic information such as date of birth, gender, and other information is stored and maintained for reporting purposes and for the provision of care.	DC \ Care Management
F03	***Manage diagnosis list***	Create and maintain client specific diagnoses.	DC \ Care Management
F04	***Manage medication list***	Create and maintain client specific medication lists- Please see DC.1.7.1 for medication ordering as there is some overlap.	DC \ Care Management
F05	***Manage allergy and adverse reaction list***	Create and maintain client specific allergy and adverse reaction lists.	DC \ Care Management
F06	***Manage client history***	Capture, review, and manage services/treatment, hospitalization information, other information pertient to clients care.	DC \ Care Management
F07	***Summarize health record***		DC \ Care Management
F08	***Manage clinical documents and notes***	Create, correct, authenticate, and close, as needed, transcribed or directly entered clinical documentation.	DC \ Care Management
F09	***Capture external clinical documents***	Incorporate clinical documentation from external sources.	DC \ Care Management
F10	***Generate and record client specific instructions***	Generate and record client specific instructions as clinically indicated.	DC \ Care Management

F11	***Order medication***	Create prescriptions or other medication orders with detail adequate for correct filling and administration.	DC \ Care Management
F12	***Order diagnostic tests***	Submit diagnostic test orders based on input from specific care providers.	DC \ Care Management
F13	***Manage order sets***	Provide order sets based on provider input or system prompt, medication suggestions, drug recall updates.	DC \ Care Management
F14	***Manage results***	Route, manage, and present current and historical test results to appropriate clinical personnel for review, with the ability to filter and compare results.	DC \ Care Management
F15	***Manage consents and authorizations***	Create, maintain, and verify client treatment decisions in the form of consents and authorizations when required.	DC \ Care Management
F16	***Support for standard care plans, guidelines, protocols***	Support the use of appropriate standard care plans, guidelines, and/or protocols for the management of specific conditions.	DC \ Care Management
F17	***Capture variances from standard care plans, guidelines, protocols***	Identify variances from client-specific and standard care plans, guidelines, and protocols.	DC \ Care Management
F18	***Support for drug interaction***	Identify drug interaction warnings at the point of medication ordering	CM \ Clinical Decision Support

F19	***Support for medication or immunization administration or supply***	To reduce medication errors at the time of administration of a medication, the client is positively identified; checks on the drug, the dose, the route and the time are facilitated. Documentation is a by- product of this checking; administration details and additional client information, such as injection site, vital signs, and pain assessments, are captured. In addition, access to online drug monograph information allows providers to check details about a drug and enhances client education.	CM \ Clinical Decision Support
F20	***Support for non-medication ordering***	Referrals, care management	CM \ Clinical Decision Support
F21	***Present alerts for disease management, preventive services and wellness***	At the point of clinical decision making, identify client specific suggestions / reminders, screening tests / exams, and other preventive services in support of disease management, routine preventive and wellness client care standards.	CM \ Clinical Decision Support
F22	***Notifications and reminders for disease management, preventive services and wellness***	Between healthcare service/treatments, notify the client and/or appropriate provider of those preventive services, tests, or behavioral actions that are due or overdue.	CM \ Clinical Decision Support
F23	***Clinical task assignment and routing***	Assignment, delegation and/or transmission of tasks to the appropriate parties.	CM \ Operations Management & Communication

F24	***Inter-provider communication***	Support secure electronic communication (inbound and outbound) between providers in the same practice to trigger or respond to pertinent actions in the care process (including referral), document non-electronic communication (such as phone calls, correspondence or other service/treatments) and generate paper message artifacts where appropriate.	CM \ Operations Management & Communication
F25	***Pharmacy communication***	Provide features to enable secure and reliable communication of information electronically between practitioners and pharmacies or between practitioner and intended recipient of pharmacy orders.	CM \ Operations Management & Communication
F26	***Provider demographics***	Provide a current directory of practitioners that, in addition to demographic information, contains data needed to determine levels of access required by the EHR security and to support the delivery of mental health services.	SS \ Clinical Support
F27	***Scheduling***	Support interactions with other systems, applications, and modules to provide the necessary data to a scheduling system for optimal efficiency in the scheduling of client care, for either the client or a resource/device.	SS \ Clinical Support
F28	***Report Generation***	Provide report generation features for the generation of standard and ad hoc reports	SS \ Measurement, Analysis, Research & Reports
F29	***Health record output***	Allow users to define the records and/or reports that are considered the formal health record for disclosure purposes, and provide a mechanism for both chronological and specified record element output.	SS \ Measurement, Analysis, Research & Reports

F30	***Service/treatment management***	Manage and document the health care delivered during an service/treatment.	SS \ Administrative & Financial
F31	***Rules-driven financial and administrative coding assistance***	Provide financial and administrative coding assistance based on the structured data available in the service/treatment documentation.	SS \ Administrative & Financial
F32	***Eligibility verification and determination of coverage***		SS \ Administrative & Financial
F33	***Manage Practitioner/Patient relationships***	Identify relationships among providers treating a single client, and provide the ability to manage client lists assigned to a particular provider.	SS \ Administrative & Financial
F34	***Clinical decision support system guidelines updates***	Receive and validate formatted inbound communications to facilitate updating of clinical decision support system guidelines and associated reference material	SS \ Administrative & Financial
F35	***Enforcement of confidentiality***	Enforce the applicable jurisdiction's client privacy rules as they apply to various parts of an EHR-S through the implementation of security mechanisms.	INI \ Security
F36	***Data retention, availability, and destruction***	Retain, ensure availability, and destroy health record information according to organizational standards. This includes: Retaining all EHR-S data and clinical documents for the time period designated by policy or legal requirement; Retaining inbound documents as originally received (unaltered); Ensuring availability of information for the legally prescribed period of time; and Providing the ability to destroy EHR data/records in a systematic way according to policy and after the legally prescribed retention period.	INI \ Health Record Information & Management

F37	***Audit trails***	Provide audit trail capabilities for resource access and usage indicating the author, the modification (where pertinent), and the date and time at which a record was created, modified, viewed, extracted, or removed. Audit trails extend to information exchange and to audit of consent status management (to support DC.1.5.1) and to entity authentication attempts. Audit functionality includes the ability to generate audit reports and to interactively view change history for individual health records or for an EHR-system.	INI \ Health Record Information & Management
F38	***Extraction of health record information***	Manage data extraction in accordance with analysis and reporting requirements. The extracted data may require use of more than one application and it may be pre-processed (for example, by being de-identified) before transmission. Data extractions may be used to exchange data and provide reports for primary and ancillary purposes.	INI \ Health Record Information & Management
F39	***Concurrent Use***	EHR system supports multiple concurrent physicians through application, OS and database.	SS \ Clinical Support
F40	***Mandated Reporting***	Manage data extraction accordance with mandating requirements.	SS \ Measurement, Analysis, Research & Reports
F41	***Administrative A/P E.H.R. Support***		
F42	***Administrative A/R E.H.R. Support***		
F43	***Administrative Workflows E.H.R. Support***		
	Security Requirements		
S01	**Security: Access Control**		
S02	**Security: Authentication**		

S03	**Security: Documentation**		
S04	**Security: Technical Services**		
S05	**Security: Audit Trails**		
S06	**Reliability: Backup/Recovery**		
S07	**Reliability: Documentation**		
S08	**Reliability: Technical Services**		
	Interoperability Requirements		
I01	**Laboratory**		DC \ Care Management
I02	**Imaging**		
I03	**Medications**		
I04	**Clinical Documentation**		
I05	**Chronic Disease Management/ Patient Documentation**		
I06	**Secondary Uses of Clinical Data**		
I07	**Administrative & Financial Data**		

MHSA - Behavioral Health Functional Functional Criteria MHSA Evaluation of EHRs

DRAFT

DMH EHR Functional Requirement Category Number	DMH EHR Functional Requirement Criteria Number	Specific Criteria	Discussion / Comments	EHR Road Map 1=Infrastructure 2=Practice Mgmt 3=Clinical Data 4=CPOE 5=Full EHR 6=Full EHR/PHR		Vendor Ratings Availability 2006	2007	2008	2009 and beyond
F-06	6.006	The system shall be able to capture client history in a standard coded form.	Not all data elements may currently be represented in existing standard coding schemes.	5		H	L	M	H
F-24	24.004	The system shall efficiently integrate with community resource databases, client wait lists, call logging, intake screening, pre-registration, registration , remote registration, and client referral systems which gather and/or distribute client demographic and financial information related to an existing or potential client.		5					
F-24	24.005	The system shall support service/treatment authorization opening, approval, deferral, denial, notice issuance, letter generation, tracking and closing for a variety of authorization types (e.g. acute inpatient, residential, outpatient), which constitute discrete episodes of care, compliant with the ASC X12N 278 - Referral Certification and Authorization format.	Includes: 1) County-Issued Internal Authorizations for clients served at county clinics; 2) County-Issued External Authorizations for clients referred to providers in the provider network as part of the county's role as a Medi-Cal mental health plan; 3) Health Plan-Issued External Authorizations to the county from other health plans and managed care companies, which are approving service/treatments to be provided by county staff or contractors.	5					
F-24	24.015	The system shall receive and upload, with proper edit checking, client registration, episode, admission, discharge, authorization, and service/treatment data from contract providers that utilize a different practice management system.		5					

I-01	**1.001**	The system shall receive general laboratory results (includes ability to replace preliminary results with final results and the ability to process a corrected result)	The test files are designed so that products implementing either the HL7 v2.4 or HL7 v2.5.1 standard will be found compliant. The test identifier will be encoded in LOINC, and will be drawn from among 52 common test codes. Refer to *2007 CCHIT Laboratory Interoperability Test Instructions and Applicant Form* for the list of these codes and more information on the interoperability test procedure.	**5**					
I-01	**1.002**	The system shall receive microbiology laboratory results	Organisms will be coded using SNOMED, Sensitivity testing will be coded using LOINC	**5**					
I-01	**1.003**	The system shall espond to a query to share laboratory results	Part of ONC EHR-Lab Use Case Will work with Ambulatory Functionality WG to align functionality criteria and interoperability roadmap dates in preparation for next round of public comments.	**5**					
I-01	**1.004**	The system shall send an order for a laboratory test	Further work is need on defining the ordering messages and codes for ordering tests, should include an EHR generated order number for tracking	**5**					
I-01	**1.005**	The system shall send a query to check status of a test order	Part of a function for closing the orders loop as part of quality improvement. Also need to be able to detect orders not matched with results.	**5**					
I-02	**2.001**	The system shall receive imaging reports and view images, includes ECG and other images as well as radiology		**5**					
I-02	**2.002**	The system shall send a query to other providers to share imaging results	see also line IA 5.6 send a query to a registry for documents	**5**					
I-02	**2.003**	The system shall respond to a query to share imaging results with other providers		**5**					
I-03	**3.001**	The system shall send an electronic prescription to pharmacy	Will be aligned with Medicare Part D final regulations	**5**					

I-03	**3.002**	The system shall respond to a request for a refill sent from a pharmacy	Transaction is now wide spread use so that systems that send new prescriptions need to be ready to respond to requests for refills.	**5**					
I-03	**3.003**	The system shall send a cancel prescription message to a pharmacy	Sent by the prescriber to cancel a prescription that was sent previously	**5**					
I-03	**3.004**	The system shall respond to a request for a prescription change from a pharmacy	Sent by the pharmacy to request that the prescriber make changes to a prescription before it is filled.	**5**					
I-03	**3.005**	The system shall send electronic prescription to pharmacy including structured and coded SIG instructions	Standard has been written but has not been finalized, balloted, or implemented. Will work with Ambulatory Functionality WG to align functionality criteria and interoperability roadmap dates in preparation for next round of public comments.	**5**					
I-03	**3.006**	The system shall send a query to verify prescription drug insurance eligibility and coverage	An essential first step prior to sending a query for medication history or formulary information directed at prescription drug coverage.	**5**					
I-03	**3.007**	The system shall access and view formulary information from pharmacy or PBM	Usually preceded by a query for insurance eligibility to verify potential source of data.	**5**					
I-03	**3.008**	The system shall send a query for medication history to PBM or pharmacy to access and view medication list from EHR	Part of ONC CE-PHR Use Case, used effectively during Medicare Part D pilots.	**5**					
I-03	**3.009**	The systems shall receive medication fulfillment history	Sent by pharmacy after medication has been dispensed to the client, not currently in wide spread use but is a priority for providers	**5**					
I-04	**4.001**	The system shall register documents with document registry	The ability to register documents in a registry or a repository will be part of the NHIN and final architecture has not been selected.	**5**					
I-04	**4.002**	The system shall send a query a document registry for documents	This criteria is for the query request. This function deals only with the document registry and repository and the references to specific documents have been removed. When the criteria are finalized, any document constraints that are required by the network standards will be identified.	**5**					

I-04	**4.003**	The system shall send documents to repository	This criteria is for sending documents to the repository. The function of sending documents to a repository may be independent of the specific types of documents that will be identified by the network standards. Use of HITSP harmonized standards is expected and it is too early to set those standards at this time.	**5**					
I-04	**4.004**	The system shall respond to a query to provide a document that was previously registered in a repository	This function refers only to the ability to provide a document that has been registered in response to a query. The ability to create documents and medical summaries are discussed in other lines below.	**5**					
I-04	**4.005**	The system shall create and send electronic documentation of a visit such as a consult letter to a referring physicians	Will include narrative data	**5**					
I-04	**4.006**	The system shall Import a clinical document such as a hospital discharge summary, a letter from a consultant, or an imaging report	Will include narrative data	**5**					
I-04	**4.007**	The system shall send Medical Summary to refer or transfer clinical care of client	Used for structured data. Use of CCR will require available translation to CCD.	**5**					
I-04	**4.008**	The system shall receive Medical Summary and import into EHR for consult or transfer of clinical care	May use direct communication or a regional network	**5**					
I-04	**4.009**	The system shall send data to PHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03	**5**					
I-04	**4.010**	The system shall receive data from PHR and import into EHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03	**5**					
I-05	**5.002**	The system shall import home physiologic monitoring data from clients	Part of AHIC Chronic Care Breakthrough, standards and implementation guides have not been selected yet	**5**					
I-06	**6.001**	The system shall send client specific Public Health Disease Report for a reportable disease	Electronic replacement for traditional reportable disease notifications to health departments, may become part of bio-surveillance in the future.	**5**					
I-06	**6.002**	The system shall send anonymous utilization and laboratory bio-surveillance data to public health agencies	ONC Bio-surveillance Use Case	**5**					

I-06	**6.003**	The system shall have Quality Improvement reporting.	Standards and implementation guides are not available yet and will be evaluated by the Work Group. An AHIC Quality Workgroup is being formed to address this.	**5**					
I-07	**7.001**	The system shall query and receive electronic insurance eligibility information	Separated this requirement from IA-3.6 to avoid duplication of criteria.	**5**					
I-07	**7.002**	The system shall send a query to coordinate client identification	Patient identification coordination will be part of network certification scheduled to begin in 2009 and is required as part of the document transport criteria.	**5**					
I-07	**7.003**	The system shall support standard interfaces to Practice Management and Billing systems.	CCHIT requires more input on stakeholder priorities and feasibility of certifying a standard interface between all EHR systems and all practice management systems and billing systems	**5**					
I-07	**7.004**	The system shall receive client registration data from a practice management system	Transfer of registration and client identification data between practice management systems and EHR is very desirable. Although earlier certification is desirable, without implementation guides, certification cannot happen.	**5**					
I-07	**7.005**	The system shall receive scheduling information from a scheduling system	Transfer of data between a practice management scheduling system and an EHR is highly desirable and is essential for some EHR operations. Although earlier certification is desirable, without implementation guides, certification cannot happen.	**5**					
I-07	**7.006**	The system shall send a query from the EHR to a scheduling system to schedule and appointment	The ability to schedule an appointment during a client encounter will require new standards	**5**					
I-07	**7.007**	The system shall receive electronic authorization for referral from payor	Only a handful of insurers are supporting this today.	**5**					
I-07	**7.008**	The system shall communicate with non-local registry services (that is, to registry services that are external to an EHR) through standardized interfaces.		**5**					
I-07	**7.009**	The system shall provide the ability to use registries or directories to uniquely identify patients for the provision of care.		**5**					
I-07	**7.01**	The system shall provide the ability to use registries or directories to retrieve links to relevant healthcare information regarding a patient that is external to the EHR application.		**5**					
I-07	**7.011**	The system shall provide the ability to use registries or directories to identify payers, health plans, and sponsors for administrative and financial purposes.		**5**					
I-07	**7.012**	The system shall provide the ability to use registries or directories to identify employers for administrative and financial purposes.		**5**					

I-07	**7.013**	The system shall provide the ability to use registries or directories to identify public health agencies for healthcare purposes.		**5**					
I-07	**7.014**	The system shall provide the ability to use registries or directories to identify healthcare resources and devices for resource management purposes.		**5**					
I-07	**7.015**	The system shall provide the ability to use standard terminologies to communicate with other systems (internal and external to the EHR).		**5**					
I-07	**7.016**	The system shall provide the ability to validate clinical terms and coded clinical data against standard terminologies.		**5**					
I-07	**7.017**	The system shall provide the ability to exchange patient data using formal explicit information models and standard terminologies.		**5**					
I-07	**7.018**	The system shall provide the ability to use a formal explicit terminology model.		**5**					
I-07	**7.019**	The system shall provide the ability to use a terminology service (internal or external to the EHR).		**5**					
I-07	**7.020**	The system shall provide the ability to use different versions of terminology standards.		**5**					
I-07	**7.021**	The system shall provide the ability to update terminology standards.		**5**					
I-07	**7.022**	The system shall relate modified concepts in the different versions of a terminology standard to allow preservation of interpretations over time.		**5**					
I-07	**7.023**	The system shall provide the ability to interoperate with systems that use known different versions of a terminology standard.		**5**					
I-07	**7.024**	The system shall provide the ability to deprecate terminologies.		**5**					
I-07	**7.025**	The system shall provide the ability to deprecate individual codes within a terminology.		**5**					
I-07	**7.026**	The system shall provide the ability to cascade terminology changes where coded terminology content is embedded in clinical models (for example, templates and custom formularies).		**5**					
I-07	**7.027**	The system shall apply changes in terminology to all new clinical content (via templates, custom formularies, etc.)		**5**					
I-07	**7.028**	The system shall provide the ability to map terminologies.		**5**					
I-07	**7.029**	The system shall provide the ability to use standard terminology services for the purposes of mapping terminologies.		**5**					
I-07	**7.030**	The system shall provide the ability for a user to validate a mapping.		**5**					
I-07	**7.031**	The system shall provide the ability to use interchange standards[1] as required by realm specific and/or local profiles.	[1]The term “Interchange Standards” refers to the common understanding of the rules governing the physical connectivity, message formats and semantics, used when disparate applications share data. Well understood interchange standards include; HL7 version 2.5, Clinical Document Architecture, X12N, etc.	**5**					
I-07	**7.032**	The system shall provide the ability to seamlessly perform interchange operations with other systems that adhere to recognized interchange standards.		**5**					
I-07	**7.033**	The system shall support terminology standards in accordance with a users’ scope of practice, organizational policy or jurisdictional law.		**5**					

I-07	**7.034**	The system shall provide the ability to exchange data using an explicit and formal information model and standard, coded terminology.		**5**					
I-07	**7.035**	The system shall provide the ability to use different versions of interchange standards.		**5**					
I-07	**7.036**	The system shall provide the ability to change (reconfigure) the way that data is transmitted as an interchange standard evolves over time and in accordance with business needs.		**5**					
I-07	**7.037**	The system shall provide the ability to deprecate an interchange standard.		**5**					
I-07	**7.038**	The system shall provide the ability to interoperate with other systems that use known, different versions of an interoperability standard.		**5**					
I-07	**7.039**	The system shall provide the ability to support standards-based application integration.		**5**					
I-07	**7.040**	The system shall use interchange agreement description standards when exchanging information with partners.		**5**					
F-06	**6.005**	The system shall be able to capture history collected from external sources (other than a personal health record (PHR))	Examples include past service/treatments, diagnoses, procedures, family history and social history and hospitalization. This could include data from online client histories, and information from pharmacy benefit management organizations. This criterion will accept any method of entry for year one, but electronic entry of information will be required thereafter. Separated the PHR into a separate requirement. See 6.014	**6**		M	H		
F-06	**6.014**	The system shall be able to capture history collected from a personal health record (PHR).	Examples include past service/treatments, diagnoses, procedures, family history and social history and hospitalization.	**6**		M	H		
I-03	**3.010**	The system shall access and view a medication history from a PHR	Part of ONC CE-PHR Use Case, may use PHR standards such as HL7/CCD and ASTM CCR instead of NCPDP standards. Will probably use RxNORM medication codes that are more appropriate for consumers and providers than the NDC codes used by pharmacies.	**6**					
I-03	**3.011**	The system shall respond to a query for medication history sent by a PHR	Part of ONC CE-PHR Use Case, may use PHR standards such as HL7/CCD and ASTM CCR instead of NCPDP standards, final standards to be specified by HITSP.	**6**					

I-04	**4.011**	The system shall receive registration summary from client and import into EHR	Use of CCR will require available translation to CCD, Use of XPHR is for interim use per HITSP IS-03	**6**					
I-05	**5.001**	The system shall secure electronic messaging with clients	Part of AHIC Chronic Care Breakthrough, standards and implementation guides have not been selected yet	**6**					
I-05	**5.006**	PHR: The system shall provide the ability to send information to a client for review via a personal health record (PHR).		**6**					
I-05	**5.007**	PHR: The system shall provide two-way communication with the client via a PHR so that the client can receive messages from the provider and the client can send the practice requests for eRX refills, appointment scheduling, and inquiries.		**6**					
I-05	**5.008**	PHR: The system shall provide the ability for the client to enter in their demographic, insurance information, family history, social history and prior medical history via a secured PHR website.		**6**					
F-03	**moved**	The system shall provide intake forms designed to display current data in the system, such as demographic items. The intake form can be designed to include various types of data including: free text, multiple choice, and drop down menu items.	Was 3.016. Moved to Manage Client Demographics: 2.018						
F-04	**moved**	The system shall trigger an alert to a user at the time a new medication is prescribed that drug interaction and allergy checking will not be performed against the uncoded or free text medication.	Was 4.019. Moved to Suppor for Drug Interaction: 18.017				H		
F-04	**moved**	The system shall allow the provider to prioritize/rank the importance of the interactions and/or warnings.	Was 4.036. Moved to Support for Drug Interaction 18.021						
F-08	**moved**	The system shall be able to capture the client's immunization history.	Was 8.053. Moved to Mange Client History: 6.013						
F-09	**moved**	The system shall be able to receive, store in the client's record, and display discrete lab results received through an electronic interface.	Was 9.002. Moved to Manage Results 14.021 This may be an external source such as a commercial lab or through an interface with on site lab equipment.			H			
F-09	**moved**	The system shall be able to accept, store in the client's record, and display clinical results received through an interface with an external source.	Was 9.007. Moved to Manage Results: 14.020 In addition to lab and radiology reports, this might include interfaces with case/disease management programs and others.			L	H		
F-09	**moved**	The system shall allow the ability to enter group progress notes .	Was 9.012. Moved to Manage Clinical Notes 8.062						

F-09	**moved**	The system shall not require the user to enter group progress notes for every client. Clinical documentation relevant to all group attendees shall only be entered once. The system shall allow display of a specific client's progress notes.	was 9.013. Moved to Manage Clinical Notes 8.063						
F-11	**moved**	The system shall trigger an alert to a user at the time a new medication is prescribed that drug interaction, allergy, and formulary checking will not be performed against the uncoded medication.	Was 11.025. Moved to Support for Drug Interaction: 18.018				H		
F-11	**moved**	The system shall be able to update drug interaction databases.	Was 11.026. Moved to Support for Drug Interaction: 18.019 This includes updating or replacing the database with a current version.						
F-11	**moved**	The system shall trigger an alert to a user if the drug interaction information is outdated.	Was 11.027. Moved to Support for Drug Interaction: 18.020 The drug database shall have an "expiration date" based on the frequency of their updates such that when that date has passed, an alert is triggered to the user.				L	H	
F-11	**moved**	The system shall support the collection of data required for the support of various pharmaceutical company indigent patient, “Patient Assistance Programs.”	Was 11.042. Moved to Eligibility Verification 32.016						
F-11	**moved**	The system shall be able to generate drug-specific "Patient Assistance Programs" applications forms to request medications at no cost from manufacturers.	Was 11.043. Moved to Eligibility Verification 32.017						
F-11	**moved**	The system shall support the configuration of multiple "Patient Assistance Programs" application forms that shall be associated with specific medications.	Was 11.044. Moved to Eligibility Verification 32.018						
F-11	**moved**	The system shall track the submission of "Patient Assistance Programs" forms and the status tracking of pending applications.	Was 11.045. Moved to Eligibility Verification 32.019						
F-30	**moved**	The system shall notify users of missing or expired authorizations for service/treatment during the data entry process.	Was 30.008. Moved to Manage Consents and Authorizations: 15.009						
F-30	**moved**	The system shall prevent inappropriate duplicative claiming of service/treatment rendered.	Was 30.017. Moved to Admin A/R 42.198						
F-30	**moved**	The system shall prevent any Medi-Cal claiming for service/treatments rendered while client is located in an Institution for the Mentally Diseased (IMD).	Was 30.018. Moved to Admin A/R 42.199						
F-30	**moved**	The system shall prevent billing Medi-Cal for board & care costs of an Psychiatric Health Facility (PHF).	Was 30.019. Moved to Admin A/R 42.200						

F-30	**moved**	The system shall have user-friendly routines for updating service/treatment charge rates.	Was 30.020. Moved to Admin A/R 42.201						
F-30	**moved**	The system shall allow payor source to be determined by both service/treatment type.	Was 30.024. Moved to Admin A/R 42.202						
F-30	**moved**	The system shall allow payor source to be determined by service/treatment program.	Was 30.025. Moved to Admin A/R 42.203						
F-30	**moved**	The system shall be able to associate a service/treatment with a funding source governed by effective start / end boundaries.	Was 30.026. Moved to Admin A/R 42.204 Examples are: 1) AB3632 IEP service/treatments; 2) Grant funding timeline restrictions; 3) Insurance company or another county authorization period boundary dates;						
F-43	**moved**	The system shall be able to flag, prevent or suspend service/treatment entry outside scope of practice. (i.e. CBT..)	Was 43.036 . Moved to Service/Treatment Management 30.027 Review again						
F-43	**moved**	The system shall simultaneously trigger alerts to users of each other's presence in the same record, where such access is permitted.	Was 43.044. Moved to Concurrent Use: 39.005						
S-01	**moved**	The system shall be able to detect security-relevant events that it mediates and generate audit records for them. At a minimum the events shall include: start/stop, user login/logout, session timeout, account lockout, cleint record created/viewed/updated/deleted, scheduling, query, order, node-authentication failure, signature created/validated, PHI export (e.g. print), PHI import, and security administration events. Note: The system is only responsible for auditing security events that it mediates. A mediated event is an event that the system has some active role in allowing or causing to happen or has opportunity to detect. The system is not expected to create audit logs entries for security events that it does not mediate.	Was 1.005. Moved to Security Audit: 5.015.				X		
S-01	**moved**	The system shall record within each audit record the following information when it is available: (1) date and time of the event; (2) the component of the system (e.g. software component, hardware component) where the event occurred; (3) type of event (including: data description and cleint identifier when relevant); (4) subject identity (e.g. user identity); and (5) the outcome (success or failure) of the event.	Was 1.006 Moved to Security Audit: 5.016.			X			X

S-01	**moved**	The system shall provide authorized administrators with the capability to read all audit information from the audit records in one of the following two ways: 1) The system shall provide the audit records in a manner suitable for the user to interpret the information. The system shall provide the capability to generate reports based on ranges of system date and time that audit records were collected. 2) The system shall be able to export logs into text format in such a manner as to allow correlation based on time (e.g. UTC synchronization).	Was 1.007 Moved to Security Audit: 5.017.			X			X
S-01	**moved**	The system shall be able to support time synchronization using NTP/SNTP, and use this synchronized time in all security records of time.	Was 1.008 Moved to Security Technical Services: 4.016.			X			X
S-01	**moved**	The system shall have the ability to format for export recorded time stamps using UTC based on ISO 8601. Example: "1994-11-05T08:15:30-05:00" corresponds to November 5, 1994, 8:15:30 am, US Eastern Standard Time.	Was 1.009 Moved to Security Technical Services: 4.017.				X		
S-01	**moved**	The system shall prohibit all users read access to the audit records, except those users that have been granted explicit read-access. The system shall protect the stored audit records from unauthorized deletion. The system shall prevent modifications to the audit records.	Was 1.010 Moved to Security Audit: 5.018.			X			X
S-01	**moved**	The system shall allow an authorized administrator to enable or disable auditing for groups of related events to properly collect evidence of compliance with implementation-specific policies. Note: In response to a HIPAA-mandated risk analysis and management, there will be a variety of implementation-specific organizational policies and operational limits.	Was 1.012 Moved to Security Audit: 5.019.				X		
S-04	**moved**	When passwords are used, the system shall not transport passwords in plain text.	Was 4.002. Moved to Security Authentication 2.017			X			X
S-04	**moved**	When passwords are used, the system shall not display passwords while being entered.	Was 4.003. Moved to Security Authentication 2.018			X			X